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M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month. However, if the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Disability Denials
- M1510.102 Foster Care Children.

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

1. CN, CNNMP, MI

The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. Medically Needy (MN)

In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: *Ms. A* applied for Medicaid for *herself* and *her* children on July 8. *She* reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; *she lost her job* in May. *She* provided all required verification for May and June, but did not provide *income verification* for April. Their application was approved for *MI Medicaid* coverage beginning May 1; April coverage was denied because of failure to verify *income* for April.

1. Excess Income In One or More Retroactive Months

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he CANNOT be eligible as medically needy in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CNNMP or MI must be approved.

EXAMPLE #2: ***(Using July 2003 figures)***
A parent of a child under age *19* applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March. She also has unpaid medical bills (*old bills)* from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of *$3,250* per month in January and February exceeded the F&C MI and the MN income limits. The income of $800 starting March 1 is within the F&C MI income limit. *The parent verifies* that the resources in January and February were within the MN resource limit, but does not verify the March resources because the income is within the MI income limits.

The application is approved for retroactive coverage as MI beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive coverage is denied for January and February.

2. Excess Income In All 3 Retroactive Months

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: ***(Using July 2003 figures)***
A parent of a child under age *19* applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March. The retroactive period is January - March.

The *worker* verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of *$3,250* in January, February and March exceeded the F&C MI and the

MN income limits. The worker verifies that their resources in January and February were within the MN resource limit, but is unable to verify the resources for March.

The application is denied for retroactive coverage as MI because of excess income and denied for MN because of failure to provide resource verification for the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: ***(Using July 2003 figures)***
Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of $*1*500 per month and received SS disability of $*1*500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN/CNNMP & MI

When an individual in the family unit meets a CN, CNNMP or MI covered group, compare each month's countable income to the appropriate CN/CNNMP or MI income limit for the month. When the countable income is within the CN, CNNMP or MI income limit in the month, the CN, CNNMP or MI individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN, CNNMP or MI unit member(s)

for that month(s) only, using the appropriate CN, CNNMP or MI covered group program designation.

2. Medically Needy (MN)

When the family unit's countable income exceeds the CN, CNNMP or MI income limit in one or more of the retroactive months, and all other Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See *subchapter M1330* for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met.

NOTE: A QMB is never eligible for retroactive coverage as a QMB only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See *subchapter M1330* to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the medically indigent Qualified Medicare Beneficiary (QMB) group begins the first day of the application month when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income, or

- when the applicant is eligible only as a medically indigent qualified Medicare beneficiary (QMB).

1. Applicant Has Excess Income

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See *subchapter M1330* to determine retroactive spenddown eligibility.

2. QMB Applicant

Entitlement to Medicaid for a medically indigent Qualified Medicare Beneficiary (QMB) begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.

3. SLMB and QDWI

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) MI covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. Applications From CSBs For IMD Patients Ages 21-64 Years

A patient who is age 21 years or older but is less than 65 years and who is in an institution for treatment of mental diseases (IMD) is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for DMHMRSAS IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends his local agency a Medicaid application which is received on August 18, 1997. The facility's statement notes that he will be discharged on September 17, 1997, to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21, 1997 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18, 1997. The patient is enrolled in Medicaid with a begin date of September 18, 1997.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. MI Pregnant Woman

For an eligible MI pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

Following the end of the postpartum period, the MI pregnant woman continues to be eligible for Medicaid in the Family Planning Services (see M0320.302) covered group for 10 months (12 months following the end of the pregnancy) regardless of any change in income.

2. Spenddown Recipients

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application.

An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the *DDS* or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for *SS/SSI* and Medicaid as disabled, and *DDS* denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application. *The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the application.* If the re-evaluation determines that the individual is eligible, entitlement is based on the date of the Medicaid application and the disability onset date. If the denied application is more than 12 months old, a redetermination using current information must also be completed.

M1510.104 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.105 DELAYED CLAIMS

A. When Applicable

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the

delayed filing was a delay in the recipient's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the recipient is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

- be dated and on the agency's letterhead stationery.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the recipient's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the recipient to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. A sample copy of such a letter is in Appendix 1 to this Chapter.

M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or recipient in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his or her claim for Medicaid benefits.

B. Notice of Action Taken on Application

The "Notification of Action on Medicaid" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.

- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. MI Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notification of Action on Medicaid") must state the reason for denial. The notice must also include the "Application For Benefits" form and must advise the applicant of the following:

a. that he/she may complete and file the enclosed application for Medicaid spenddown, and

b. if he/she files the application (Application For Benefits) within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for medically indigent Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for Medicaid because of excess resources.

b. Excess income

1) If the QMB's resources are within the medically indigent limit but are over the medically needy limit, and the income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for medically needy spenddown because of excess resources. The notice must specify the dollar amount of the appropriate medically needy resource limit.

2) If the QMB's resources are within the medically needy limit, and income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for Medicaid because of excess income, but that the applicant can spenddown his/her income to become eligible. The notice must specify the spenddown amount, the spenddown period begin and end dates, and should include information about how spenddown works (such as the "Virginia Medicaid Handbook" or the spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time.

Only one "Notification of Action on Medicaid" (Form 032-03-008) is sent to the applicant covering both actions. Statements of the exact dates of Medicaid coverage entitlement, the date entitlement ends, and the reason(s) for ineligibility must be included on this notice.

Example #7: An application for Medicaid is filed on December 5. The agency takes action on this application in February. The client was determined eligible for Medicaid effective December 1 and through January. Because of his inheritance of real property on January 30 which exceeds the resource limit, he is ineligible for ongoing benefits after January 31. One notice is sent to the applicant stating that his Medicaid application was approved with Medicaid coverage beginning December 1 and ending January 31, and that he is denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a “last pay” program and cannot pay any claim for service until the service provider has filed a claim with the recipient’s liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on private health insurance coverage must be obtained and recorded in the eligibility record and the computer TPL file. This must include the company name (code number for the TPL file), the policy number, and the beginning date of the policy coverage. Health insurance policy or coverage changes which occur after application must be updated in the eligibility record and TPL file.

If a member of the assistance unit is employed more than 30 hours per week, the HIPP Application and Medical History Questionnaire must be sent to the HIPP Unit at DMAS. See the HIPP requirements in M0290.

C. Medicare

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN, CNNMP or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);

- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Health Care Financing Administration (HCFA) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before HCFA will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the Medicaid computer and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

a. SSA claim numbers consist of a nine-digit number followed by a letter or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with their name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the computer eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not

know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

4. Buy-in Begin Date

Some individuals have delay in Buy-in coverage:

Classifications	Buy-in Begin Date
Category Needy *Cash Assistance*	1st month of eligibility
ABD MI (includes dually-eligible)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income ≤ 100% FPL and Medicare Part A)	*1st month of eligibility*
Categorically Needy Non-money Payment and Medically Needy who are *not dually-eligible (countable income > 100% FPL or no Medicare Part A)*	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Support

In order to continue to be eligible for Medicaid an individual, who is required to cooperate with the Division of Child Support Enforcement (DCSE), must continue to cooperate with DCSE. See subchapters M0250 and M0260 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

To be eligible for Medicaid, an applicant (except an illegal alien or a child under age 1 born to a Medicaid-eligible mother) must provide his/her Social Security account number(s) to the agency, or must apply for a Social Security number if he/she does not have one.

B. Procedures

1. Documentation

If the applicant does not have a Social Security number, the agency must document in the record when he/she has applied for a number and must record the Social Security number application date in the MMIS computer recipient eligibility file when enrolling the applicant in Medicaid.

2. Follow-up

The agency must follow-up this action within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

- document the recipient's assigned Social Security number in the case record,
- enter the recipient’s Social Security number on the MMIS computer recipient eligibility file.

M1510.303 PATIENT PAY NOTIFICATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient’s patient pay must be determined. When the patient pay amount is initially established or when it is changed, a written notice must be sent to the recipient or the recipient's authorized representative.

B. Procedure

When patient pay is determined, the "Notice of Obligation for Long-Term Care Costs" form must be sent. For any subsequent decrease in patient pay, the form will serve as adequate notice.

When patient pay increases, the "Notice of Obligation for Long-Term Care Costs" form must be sent in advance of the date the new amount is effective. Following the advance notice period, the new DMAS-122 is released to the provider, if an appeal was not filed.

SAMPLE "ELIGIBILITY DELAY" LETTER TO MEDICAL PROVIDERS

- AGENCY LETTERHEAD -

RE: RECIPIENT's NAME: _____

ADDRESS: _____

SSN: _____

MEDICAID #: _____

MEDICAID COVERAGE DATES: _____

Dear Medicaid Service Provider:

_____ was recently enrolled in Medicaid,
(Medicaid Recipient's Name)

effective _____. The delay in enrollment was because of a delay in eligibility
(Date)

determination that was beyond the recipient's control.

To obtain Medicaid payment for covered services provided over 12 months ago, but within the recipient's coverage

period, attach this letter to your invoice and submit the invoice and letter to:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Attention: Claims Processing Unit

Thank you for your cooperation.

Sincerely,

Agency Representative

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ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 20

MEDICAID ELIGIBILITY REVIEW

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M1520.000 MEDICAID ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the recipient's circumstances that might *affect the recipient's continued Medicaid eligibility*.

An annual review of all of the recipient's Medicaid eligibility requirements is called a *"renewal."* A *renewal* of the recipient's eligibility must be completed at least once every 12 months.

When a Medicaid recipient no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

The recipient must be informed of the findings of partial reviews and renewals and the action taken. The Notice of Action is used to inform the recipient of continued eligibility and the next scheduled renewal. The Advanced Notice of Proposed Action is used to inform the recipient of a reduction in benefits or termination of eligibility.

B.* Procedures For Partial Review and *Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for partial reviews are in section M1520.100;
- the requirements for *renewals* are in section M1520.200;
- the policy and procedures for canceling a recipient's Medicaid coverage or reducing the recipient's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for extended Medicaid coverage are in section M1520.500;
- the policy and procedures for transferring cases within Virginia are in section M1520.600.

M1520.100 PARTIAL REVIEW

A. Recipient's Responsibility

The recipient has a responsibility to report changes in his circumstances which may affect his eligibility, patient pay or HIPP premium payments within 10 days from the day the change is known.

B. Eligibility Worker's Responsibility

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of SSA benefits and the delivery date for a pregnant woman.

When changes in a recipient's situation are reported by the recipient or when the agency receives information indicating a change in a recipient's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the recipient's continued eligibility. A reported increase in income and/or resources can be acted on without requiring verification. When a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group the reported change must be verified.

A HIPP Application and Medical History Questionnaire must be completed when it is reported that a member of the assistance unit is employed more than 30 hours per week *and is eligible for coverage under an employer's group health plan.* The eligibility worker must report to the HIPP Unit at DMAS any changes in a recipient's situation that may affect the premium payment.

C. Time Standard

Appropriate agency action on a reported change must be taken within 30 days of the report.

D. Covered Group Changes

1. Newborn Child

When a child is born to a Medicaid-eligible woman (including an emergency services alien certified for Medicaid payment for labor and delivery), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth and that the child is living with the mother. This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may not require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman *(including an emergency services alien certified for Medicaid payment for labor and delivery) is not required* until the month in which the child turns one year old, unless there is *an* indication that the child is no longer living with the mother. If the child continues to live with the mother, *an application and an eligibility determination must be completed prior to MMIS cut-off in the month* the child turns one year old.

If the child is no longer living with the mother, the child's caretaker must be given the opportunity to file an application and receive an eligibility determination prior to the agency taking action to cancel the child's coverage.

2. Child Turns Age 6

When a child who is enrolled as an MI child turns age 6, the child's PD in MMIS will automatically be changed to 92 or 94. No action is required when the child is enrolled as PD 92. If the child is enrolled as PD 94, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in PD 94 effective the end of the month and reinstate coverage in PD 92 effective the first day of the following month. **Do not use change transactions to move a child to or from PD 94.**

3. SSI Medicaid Recipient Becomes a Qualified Severely Impaired Individual (QSII) – 1619(b)

When an SSI Medicaid recipient loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) - 1619(b) covered group may exist. A *partial* review to determine the individual's 1619(b) status in SVES must be completed. To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the PD to the appropriate PD.

M1520.200 *RENEWAL* REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid recipients, with respect to circumstances that may change, at least every 12 months. An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

The first 12-month period begins with the month of application for Medicaid. S*ubsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month of the last renewal. Monthly annual renewal lists are generated by the MMIS. These lists notify eligibility workers of recipients due for renewal.*

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Individuals cannot be required to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth, Social Security number or United States citizenship.

An ex parte renewal is an internal review of eligibility based on available information. By relying on information available, the agency can avoid unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. Local departments of social services are required to conduct renewals of ongoing eligibility through an ***ex parte renewal*** *process when the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility, there is no resource test, and recipient is not receiving long-term care (LTC) services. Individuals in the SSI Medicaid covered group may have an ex parte renewal unless they reported ownership of non-exempt real property.*

If ongoing eligibility cannot be established through an ex parte renewal because the individual's covered group has a resource test or he receives LTC services or the ex parte renewal suggests that the individual may no longer be eligible for Medicaid, the agency must provide the individual the opportunity to present additional or new information using the Medicaid Renewal, form #032-03-669, (see M1520, Appendix 2) and verifications necessary to determine ongoing eligibility before the coverage is cancelled.

B. Renewal Requirements and Time Standard

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentially requirements) in order to conduct eligibility renewals.

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. The recipient must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advanced Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility. Renewals must be completed prior to cut-off in the 12th month of eligibility.

1. Ex Parte Renewal Process

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all

programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files. Income verification less than 6 months old can be used unless the agency has reason to believe it is no longer accurate.

When the recipient has reported that he has no income ($0 income), the recipient must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the recipient has reported $0 income.

The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

When an ongoing F&C Medicaid recipient applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

The recipient is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.

2. Medicaid Renewal Form

When a Medicaid Renewal form is required, the form must be sent to the recipient no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the recipient to sign and return or can be mailed to the recipient for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the recipient has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

C. Special Requirements for Certain Covered Groups

1. Pregnant Woman

A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Cancel her coverage as a pregnant woman effective the last day of the month in which the 60th day following the end of her pregnancy occurs. Reinstate coverage in the Family Planning Services (FPS) limited-coverage group effective the first day of the following

month unless information available to the agency establishes her eligibility in a full-benefit covered group. Do not use change transactions to move an individual between full and limited coverage

2. FPS

The Medicaid eligibility of women in the FPS covered group must be evaluated 12 months following the end of the pregnancy. If eligible in a full-benefit covered group, cancel her FPS coverage in the MMIS using cancel code "008"effective the last day of the month prior to the month of eligibility for full coverage, and reinstate full coverage the first day of the month of eligibility for full coverage. If eligible only for FPS, she is entitled to an additional 12 months of FPS coverage.

3. Newborn Child Turns Age 1

A renewal *for a child enrolled as a Newborn Child Under Age 1* must be done *before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group* and must include:

- *an* application (see M0120.300)
- SSN or proof of application
- *verification of* income
- *verification of* resources for the MN child.

4. Child Under Age 19 (FAMIS Plus)

The Medicaid eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is enrolled in FAMIS and there is no break in coverage. **Do not use change transactions to move a child between Medicaid and FAMIS**. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage

5. MI Child Turns Age 19

When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

6. Child Turns Age 21

When a recipient who is enrolled as a child under age 21 attains age 21, determine if the recipient meets the definition for another covered

group. If the recipient does meet the definition for another covered group, obtain the information to determine if the individual's resources and income are within the applicable limits. If the individual is eligible in another covered group, change the individual's aid category in the MMIS.

If the individual does not meet a definition for another covered group, send an advance notice and cancel the individual's Medicaid coverage because the individual does not meet a Medicaid covered group.

If the individual meets the definition for medically needy coverage but is not eligible because of income, send an advance notice and cancel the individual's Medicaid coverage because of excess income, and place the individual on a medically needy spenddown.

7. IV-E FC and AA and Special Medical Needs AA Children From Another State

For FC or AA children placed by another state's social services agency, verification of continued IV-E or non-IV-E special medical needs status, current address, and TPL can be obtained from *agency records*, the parent or the other state.

8. Breast and Cervical Cancer Prevention and Detection Act *(BCCPTA)*

The BCCPTA Application/Redetermination, form #032-03-384, is used to redetermine eligibility for the BCCPTA covered group. The *renewal* form is available on-line at http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/General/Breast_and_Cervical_Cancer_Prevntion-Treatmnt_Act_032-03-653.pdf. The recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

9. SSI and QSII (1619(b)) Covered Group Recipients

For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SVES. If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

***D.* Recipient Becomes Institutionalized**

When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.

E. LTC

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 (see Appendix 5 to subchapter M1410) for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.

Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the recipient's Medicaid services must be reduced, the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. *If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The "Advance Notice of Proposed Action" must inform the recipient of the last day of Medicaid coverage.*

B. Change Results in Adverse Action

1. Services Reduction

When information is secured that results in a reduction of Medicaid services to the recipient or a reduction in the Medicaid payment for the recipient's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before the adverse action is taken. The adverse action must not be taken, however, if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer notifies the local agency of whether the appeal was filed before the action date.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

2. Adverse Action Resulting from Computer Matches

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

The following chart indicates some of the computer match sources which require a ten (10) day advance notice.

Match Source	Notification Period
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days

D. Procedures

1. Action Appealed

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer will notify the local agency whether to continue coverage during the appeal.

If the recipient requests an appeal hearing before the effective date, the Recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS's decision.

2. Death of Recipient

Adequate notice of cancellation must be sent to the estate of the recipient at the recipient's last known address when information is received that the recipient is deceased. The effective date of cancellation in the MMIS computer eligibility file is the date of death.

3. End of Spenddown Period

When eligibility automatically terminates at the end of a six-month spenddown period, advance notice is not required. The limited period of spenddown eligibility is identified on the individual's Medicaid card and on the "Notice of Action on Medicaid" sent at the time the application is approved. Explanation of this limitation and information relative to reapplication is provided at the time of the eligibility determination and enrollment.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

1. MMIS Computer Transaction

A case must be canceled in the Medicaid computer prior to the date of the proposed action. The change to the MMIS recipient file must be made after cut-off in the month before the month the proposed action is to become effective. For example, if the notice of action specifies the intent to cancel on October 31, a change to the Medicaid computer is made after cut-off in September and before cut-off in October.

In the event the proposed action is not taken or an appeal is filed prior to the proposed date of action, the case must be immediately reopened.

2. Reason "12" Cancellations

When information is received from the Department of Medical Assistance Services that a case is canceled for cancel reason "12", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the form "Notice of Action on Medicaid." Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

M1520.403 RECIPIENT REQUESTS CANCELLATION

A recipient may request cancellation of his Medicaid coverage. The request must be written and documented in the record. When the recipient requests cancellation of Medicaid, the local department must send a Notice of Action on Medicaid form #032-03-008 to the recipient no later than the effective date of cancellation. On the notice, check the "other" block and list the reason as "recipient's request." If action to cancel the case is taken after MMIS cut-off, request the recipient return the Medicaid card to the agency. Cancel Medicaid coverage in the MMIS using the cancel reason "04".

M1520.500 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

NOTE: Children must first be evaluated for Medicaid eligibility in the MI Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate MI Child Under Age 19 PD. If ineligible as MI, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage.

B. Procedure

The policy and procedures for the four-month extension are in section **M1520.501** below.

The policy and procedures for the twelve-month extension are in section **M1520.502** below.

M1520.501 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or Increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid, erroneously during 3 or more of the 6 months proceeding the month of ineligibility does not qualify for the Medicaid extension.

2. New Family Member

A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.

3. Moves Out of State

Eligibility does not continue for any member of the family unit who moves to another state.

4. Coverage Period

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.

5. Program Designation

Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The program designation for the recipients in the unit remains "81" or "83."

6. Case Handling

Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate program designation changes to the computer file.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

M1520.502 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received *LIFC* Medicaid in 3 of 6 Months

The family received LIFC *Medicaid* in at least 3 of the 6 months immediately proceeding the month in which the family became ineligible for LIFC.

2. Cancel Reason

LIFC *Medicaid* was canceled solely because of:

- the caretaker/relative's new employment,
- the caretaker/relative's increased hours of employment,
- the caretaker/relative's increased wages of employment, or
- expiration of any assistance unit member's $30 plus 1/3, or $30, earned income disregard.

3. Has A Child Living in Home

The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. Complies With HIPP

The family complies with the Health Insurance Premium Payment (HIPP) Program requirements. (See subchapter M0290).

5. No Fraud

The family has not been determined to be ineligible for LIFC *Medicaid* because of fraud any time during the last six months in which the family received LIFC *Medicaid*.

C. Entitlement

Entitlement does not continue for any member of the unit who moves to another state.

Cases receiving this extension are categorically needy non-money payment, program designation (PD) "81".

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC *Medicaid* because of excess income due to any unit member's expiration of the $30 plus 1/3 or $30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).

a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC *Medicaid* could be taken in a timely manner, the extension period begins the month following the month the assistance unit would have last received LIFC *Medicaid* if reported timely. For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month the family's LIFC *Medicaid* should not have been received. Further,

the screening period to determine if month the family unit received LIFC *Medicaid* in at least 3 of the six months immediately preceding the month in which the unit became ineligible for LIFC *Medicaid* will be November to April.

b. Simultaneous Income Changes

In situations where an earned income case has simultaneous income changes which cause LIFC *Medicaid* ineligibility, such as new or increased earned income plus an increase in support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings or loss of the disregards. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income or loss (expiration) of the disregards.

1. If the family would have been ineligible for one of these reasons, it will be considered the reason for LIFC *Medicaid* ineligibility and the family is eligible for the 12-month Medicaid extension.

2. If, however, the family would have continued to be eligible for LIFC *Medicaid* if the only change had been increased earnings or expiration of the disregards, the other changes which occurred simultaneously will be the reason for LIFC *Medicaid* ineligibility. The family is **not** eligible for the Medicaid extension.

2. Extension Ends

Entitlement to Medicaid under this extension period terminates at the end of the first month in which the family unit ceases to include a child under age 18 or under age 19 if in school, the family unit fails to comply with the Health Insurance Premium Payment (HIPP) Program requirements or the reporting requirements in D below, or at the end of the extension period.

The child(ren)'s eligibility for Medicaid under another covered group and/or classification must be determined prior to canceling the child(ren)'s Medicaid coverage. An "Advance Notice of Proposed Action" must be sent prior to canceling extended Medicaid coverage.

D. Notice and Reporting Requirements

1. LIFC *Medicaid* Cancellation Month

When LIFC *Medicaid* is canceled, the unit must be notified of its entitlement to extended Medicaid coverage for six months, and that Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school.

The unit must be instructed to retain verifications of all earnings received and the costs of child care during each month of the extension, and to send the "Medicaid Extension Earnings Report,"and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period.

The names of the three months in the three-month period must be written out on the notice form and the report form whenever either form is sent to the family unit.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report", with the earnings and child care cost verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by the Medicaid computer if the correct indicator code and effective date of the 12-month extension are entered in the base case information fields. If the code and effective date are not entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

The Medicaid computer will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial indicator code and extension effective date were entered correctly, and the indicator code is not updated because the report was not received on time. If the indicator was not entered correctly, the agency must manually send the advance notice of Medicaid cancellation and must cancel the family's coverage in the computer after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid under another covered group or classification must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income, and resources. If the child is eligible, change the child's enrollment to the appropriate program

designation **before the cut-off date** of the sixth extension month. If not eligible, leave the child's enrollment (and the base case special review field) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, the computer will cancel coverage. The agency must then reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The indicator code must be changed in the Medicaid computer base case information when the report is received in order for Medicaid to continue. No action is taken on the first three-month period's earnings and the extension continues.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month) with the earnings and child care cost verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

The Medicaid computer will automatically send this notice if the indicator code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. The Medicaid computer will send the advance notice and automatically cancel coverage if the report is not received on time and the indicator code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are, illness or injury of family member(s) who is capable of obtaining and sending the material; agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid under another category or classification must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income, and resources. If the child is

eligible, change the child's enrollment to the appropriate program designation before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (and the base case special review field) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the base case indicator code in the Medicaid computer immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or under age 19 if in school, lives with the family;

2) the family disenrolls from a group health plan that DMAS has determined cost-effective or fails to pay the premium to maintain the group health plan;

3) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to the caretaker/relative's involuntary lay-off, the business closed, etc., the caretaker/relative's illness or injury, or other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work); or

4) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the *185% poverty* income limit appropriate to the family unit size.

See subchapter M0710, Appendix 7 for the 185% poverty income limits

d. Calculate Family's Gross Earned Income

1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-

month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No disregards are allowed.

2) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

3) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-months' cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% poverty limit for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid under another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family's total income, including earned and unearned income, and resources. If eligible, change the enrollment to the appropriate program designation before cut-off in the eighth extension month.

2) If the family is ineligible because of excess income, cancel Medicaid coverage and place the family members who meet a medically needy covered group on spenddown.

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for the extension, no action is required until the ninth month of extension, except to be sure that the indicator code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings and child care cost verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

The Medicaid computer will automatically send this notice if the correct indicator code is in the base case information on the computer. If it is not, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. The Medicaid computer will automatically cancel coverage and send the advance notice if the report is not received on time and the indicator code is not changed. Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid under another covered group must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, and resources. If eligible, change the child(ren)'s enrollment to the appropriate program designation before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (and the base case special review field) as it is and the computer will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eleventh extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the base case indicator code in the Medicaid computer immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family's income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid under another category and/or classification. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.

If the family is ineligible because of excess income and all other eligibility factors are met, cancel Medicaid and place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action**.

e. Family Remains Entitled To Extended Medicaid

If the family remains entitled to extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination.

The Medicaid computer will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the indicator code was updated correctly. Therefore, for any of the family members that remain eligible, the PD (if applicable) and the indicator code must be changed before cut-off of the twelfth month.

If all eligibility factors are met except income, place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month. The spenddown period begins the first day of the following month.

M1520.503 TRANSITIONAL MEDICAID BENEFITS

The Transitional Medicaid extension expired June 30, 2003 and was only applicable to VIEW participants who did not qualify for the Twelve-Month extension.

M1520.600 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DMHMRSAS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.

D. DMAS Medicaid Unit (FAMIS Plus Unit) FIPS 976

The Medicaid cases approved by the DMAS Medicaid unit, FIPS 976, must be transferred to the local agency where the recipient lives. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS Medicaid unit. Cases from the DMAS Medicaid unit do not require a re-evaluation until the annual renewal is due.

Medicaid cases are not transferred from local agencies to FIPS 976.

E. Locality to Locality

When a Medicaid applicant/recipient (including a Medicaid CBC waiver services recipient) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or a group home with 4 or more beds) in another locality within the State of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

The sending locality must *make certain the case is current and complete before transferring the case. If due, the annual renewal must be completed; however, if the case is a combined Food Stamp and Medicaid case, do not delay transferring the case when the renewal is due and an ex parte renewal cannot be done. Send the Medicaid Renewal form to the recipient with instructions to return it to the local agency in the new locality.*

If the annual renewal has been completed within the past 11 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, *must be completed*.

If the *renewal or the* partial review finds that eligibility no longer exists, the agency must take the necessary action, including advance notice to the individual, to cancel coverage and to cancel the case in the MMIS.

If the *renewal or the* partial review indicates that the recipient will continue to be eligible for Medicaid in the new locality, the sending locality must update the MMIS that the new locality can accept the case for transfer. The sending locality must prepare the "Case Record Transfer Form" and forward it, with the case record, to the department of social services in the new locality of residence.

Pending applications must be transferred to the new locality for an eligibility determination.

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or at the agency's discretion the case may be sent via the courier pouch.

2. Receiving Locality Responsibilities

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in the MMIS.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

2. Receiving Locality Responsibilities

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

Commonwealth of Virginia
Department of Social Services
Medicaid Program

NOTICE OF EXTENDED MEDICAID COVERAGE

Case Number
Worker Number

Client Name	Local Social Services Department
Address	Address
City/State/Zip	City/State/Zip

Please read the item checked below. It will tell you about your entitlement to extended Medicaid coverage.

❑ 1. Your countable income is over the income limit for Medicaid. However, your Medicaid is extended and will continue for six months if a dependent child continues to live with you throughout the period, and you apply for any health coverage offered by your employer. Your six months of extended coverage begins _____.

You may also be eligible for a second six months of extended Medicaid. A Medicaid Extension Earnings Report form will be mailed to you every three months. Since you will have to attach verification of earned income and child care expenses to the report, keep all paycheck stubs or other verifications of earned income for any working member of your household and verifications of child care expenses you had for each month you receive extended Medicaid.

❑ 2. You may be eligible for additional months of Medicaid coverage if you complete, sign and return the Medicaid Extension Earnings Report on the reverse side of this notice. The report is for the months of _____, _____, and _____. Attach all paycheck stubs, or other earned income verifications for each working member of your household for each month in the report period. Also, attach verifications of the child care expenses for each month. The completed and signed Medicaid Extension Earnings Report must be received by your local social services agency no later than the 21st of _____. If you are not able to complete and send the report by this date, please contact your worker at the local social services agency.

If the report is not returned, your Medicaid coverage will be cancelled effective _____.

_____	_____	_____	_____
Worker Name (Print)	Worker Signature	Telephone No.	Date

032-03-728/2 (12/00)

Commonwealth of Virginia
Department of Social Services

REPORT FOR THE MONTHS OF
_____

MEDICAID EXTENSION EARNINGS REPORT

To enable us to determine if your Medicaid coverage will continue, you must **complete, sign and return this form** to the local department of social services **by the 21st day of** _____. If you are unable to meet this deadline, contact your worker immediately.

*** * * * * * * * * You must circle yes or no for each question * * * * * * * * ***

Yes No 1. Did you, or anyone in your household who receives Medicaid, work during the past three months? If yes, complete the list below. List each month's and each person's earnings on a separate line.

Attach all pay stubs or proof of gross earnings received **each month** for all persons who worked.

Name of Person Who Worked	Employer	Month	Total Gross Monthly Pay Before Any Deductions

Yes No 2. Did you have to pay for child care because you work? If yes, complete below. Attach verification of each month's child care expense.

Name of Child	Month	Cost of Childcare Each

Yes No 3. Did you or anyone in your household stop working for any reason during the past three months? If yes, explain.

_____

_____

Yes No 4. Did any child or children move out of your home? If yes, who moved out and when?

_____

_____

Yes No 5. Have you moved or do you plan to move? If yes, indicate the date of the move and your new address.

_____

_____

I understand that the answers I give on this form will be used to determine my continued eligibility for extended Medicaid coverage. I understand that I must answer every question on this form, attach applicable earned income and child care expense verifications, sign and return this form. I understand that if I am notified that I have submitted an incomplete report, I can satisfy the reporting requirement by submitting a complete, signed report with the applicable income and child care expense verifications. I also understand that if I do not agree with the decision made on my case, I can appeal in writing and have a fair hearing at which I can present my case or have it presented by any person I choose.

I certify that the information given on this form is correct and complete to the best of my knowledge. **I AM AWARE THAT IF I PROVIDE FALSE INFORMATION, I MAY BE BREAKING THE LAW AND COULD BE PUNISHED BY IMPRISONMENT AND/OR A FINE.** I also may be disqualified from receiving Medicaid for up to one year if convicted of fraud.

_____ _____ _____
Signature Date Telephone No.

NOTICE OF EXTENDED MEDICAID COVERAGE AND MEDICAID EXTENSION EARNINGS REPORT

FORM NUMBER - 032-03-728/2 (12/00)

PURPOSE OF FORM - This form is used to inform the recipient of eligibility for extended Medicaid and the reporting requirements. This form can also be used to request earned income and child care expense verifications for reporting months when the MMIS computer-generated report is not sent.

USE OF THE FORM - The notice of Extended Medicaid Coverage must be sent manually by the agency at the time the family becomes ineligible for LIFC Medicaid. This notice does not replace the "Advance Notice of Proposed Action"; it is sent in addition to the Advance Notice when the family becomes ineligible for LIFC Medicaid.

NUMBER OF COPIES - Original and one copy.

DISPOSITION OF FORM - The original is sent to the recipient and the copy is filed in the case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information for both the recipient and the agency in the top portion of the "Notice of Extended Medicaid Coverage" form.

Section 1: Section 1 is used to inform the recipient of the beginning of extended Medicaid. In the blank, enter the first month of extended Medicaid. This is the month following the month in which the family became ineligible for LIFC (non-VIEW) Medicaid.

Section 2: Section 2 must be completed and sent by the agency in the third, sixth and ninth months of the extension if the Medicaid computer does not generate the notice. The computer will not generate the notice if the agency has not entered the correct indicator code and extension effective date in the Medicaid computer's base case eligibility file (special review field) or if the agency does not update the indicator code on time. Indicate the three months covered by the report. Write out the names of the months and indicate the year. For example, write "December 2000, January and February 2001." The second blank line must indicate that the report and attached verifications must be returned to the local social services agency by the 21st day of the 4th, 7th or 10th month, whichever is correct for the reporting period.

In the last paragraph, the worker must enter the date on which Medicaid coverage will be canceled if the client fails to comply with the reporting requirements.

On the reverse side of the "Notice of Extended Medicaid Coverage" is the "Medicaid Extension Earnings Report." At the top is a blank line labeled "Report for Months". Enter the names and year(s) of the three months in the period that this report must reflect.

The first paragraph of this report is an explanation of the client's responsibility to complete the form and return it by the prescribed date. The appropriate 4th, 7th or 10th month must be entered on the blank line in this paragraph.

Commonwealth of Virginia
Department of Social Services (DSS)
Medicaid Program

MEDICAID RENEWAL

DATE MAILED _____

DSS WORKER _____

DSS WORKER TELEPHONE _____

LOCAL AGENCY _____
ADDRESS
_____

CASE NUMBER _____

Name: _____ Address: _____

Please answer questions where the block is checked. If you have any questions or need help completing the form, please call the worker listed above. Please return this form to your eligibility worker by: _____

1. ☐ **Has anyone moved into or out of your household since your last eligibility determination?**
   ☐ **No** ☐ **Yes If yes, tell us who moved in and who moved out.** _____
   _____

2. ☐ **List all the income received during the past month and attach proof. Include income from sources such as wages, support, disability, retirement, Veteran's benefits, unemployment, rental property, etc.**

Who Receives Income	Source	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

3. ☐ **Do you have child care expenses?** ☐ **No** ☐ **Yes If yes, list child and child care costs.** _____
   _____.

4. ☐ **If you have a child under age 19 who is working, is your child still in school?** ☐ **No** ☐ **Yes**

5. ☐ **Have you had a change in your health insurance since your last eligibility determination?**
   ☐ **No** ☐ **Yes If yes, list the company, coverage type, policy number and explain change.**
   _____

6. ☐ **Do you or anyone for whom your are applying have any resources such as bank accounts, vehicles, life insurance, burial arrangements and/or real property?** ☐ **No** ☐ **Yes If yes, list each resource and attach proof of the current value. Have you sold or given away any resources?** ☐ **No** ☐ **Yes If yes, explain what you sold or gave away, the date you did this, and what you received in return.**
   _____
   _____

I have given true and correct information on this form to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain any information needed to review my eligibility.

_____ _____
Signature of Recipient or Authorized Representative **Date**

_____ _____
Relationship to Recipient **Telephone Number**

Voter Registration. Check one of the following:

( ) I am not registered to vote where I currently live, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote. Please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to

Medicaid Renewal

FORM NUMBER - 032-03-669

PURPOSE AND USE OF FORM - To report information needed to complete Medicaid renewal.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The completed form is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM – If the form is mailed, it must be sent to the recipient no later than the 11th month of eligibility. The form may be completed by an agency representative during a telephone interview and sent to the recipient for a signature or mailed to the recipient for completion. The form may also be completed by the client during an in-office interview although a face-to-face interview is not required.

Verification of income or resources will normally be required.

Upon completion of the form, the EW must evaluate the information to determine continued eligibility for Medicaid. Recipient must be sent notice of action on the renewal.

If the form is completed and returned to the agency timely and additional information and/or verification is needed, the recipient must be notified in writing of the information and/or verification needed. If the household does not complete and return the form by VaMMIS cut-off in the 12th month of eligibility, the agency must send the Advance Notice of Proposed Action to close the case effective at the end of the 12th month.

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 50

DMHMRSAS FACILITIES

TABLE OF CONTENTS

M15 ENTITLEMENT POLICY & PROCEDURES

M1550.000 DMHMRSAS FACILITIES

M1550.000 DMHMRSAS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

The Department of Social Services' Division of Benefit Programs has six eligibility workers, called Medicaid Technicians, located in three Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (DSS) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.

B. Procedures

This subchapter contains a list and a brief description of the DMHMRSAS facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a DMHMRSAS facility (M1550.400).

M1550.200 FACILITIES

A. Introduction

Three types of medical facilities are administered by DMHMRSAS: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. Training Centers

Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.

Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

The State training centers are:

- Central Virginia Training Center – Lynchburg
- Southside Virginia Training Center – Petersburg
- Northern Virginia Training Center – Fairfax
- Southeastern Virginia Training Center – Chesapeake
- Southwestern Virginia Training Center - Hillsville

2. Psychiatric Hospitals

Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

Patients in psychiatric hospitals may be Medicaid eligible only if they are

- Under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- Age 65 years or older,

And they met all non-financial and financial Medicaid eligibility requirements. The following are psychiatric hospitals, offering differing levels of care:

- Eastern State Hospital – Williamsburg
- Central State Hospital – Petersburg
- Western State Hospital – Staunton
- Northern Virginia Mental Health Institute – Falls Church
- Southern Virginia Mental Health Institute – Danville
- Southwestern Virginia Mental Health Institute – Marion
- Piedmont Geriatric Hospital – Burkeville
  Only admits patients age 65 and older
- Catawba Hospital – Catawba
  Only admits patients age 65 and older
- DeJarnette Center – Staunton
  DeJarnette is a psychiatric hospital for adolescents between the ages of 4 and 18 (must leave at age 18). Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in DeJarnette can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

3. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DMHMRSAS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DMHMRSAS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M1550.300 MEDICAID TECHNICIANS

A. Introduction

The Medicaid Technicians listed below share responsibilities for the DMHMRSAS facilities assigned to their caseloads. The listing of the Medicaid Technicians and the facilities in the next column do not correspond to caseload, but indicate all the facilities assigned to the

Technicians located at that site. Specialized services are provided by DMHMRSAS at each facility.

B. Medicaid Technicians

MEDICAID TECHNICIAN	FIPS/FACILITIES
Jane P Markham (804) 524-7581	996 Central State Hospital Hiram Davis Medical Center
Janet N. Benton (804) 524-7582	998 Southside Virginia Training Center
	994 Eastern State Hospital

Send cases to: Medicaid Technician
Central State Hospital
P.O. Box 4030
Petersburg, VA 23803

Mary L. Spiggle (804) 947-6256	990 Central Virginia Training Center
	983 Southern Virginia Mental Health Institute
Faye Parr (804) 947-2136	
	988 Northern Virginia Mental Health Institute
	997 Catawba Hospital
	991 Western State Hospital

Send cases to: Medicaid Technician
Central Virginia Training Center
P.O. Box 1098
Lynchburg, VA 24505

Norma W. Phillips (540) 783-1200	992 Southwester VA Mental Health Institute
Debra Fauber (540) 783-1200	984 Southwestern VA Training Center
	985 Southwestern VA Training Center
	986 Northern Virginia Training Center
	993 Piedmont Geriatric Hospital

Send cases to: Medicaid Technician
Southwestern VA Mental Health Institute
502 E. Main Street
Marion, Va 24554

M1550.400 CASE HANDLING PROCEDURES

A. Introduction

Effective July, 1994, the Medicaid cases handled by local departments of social services and cases of patients in DMHMRSAS facilities will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a DMHMRSAS facility or leaves the DMHMRSAS facility to live in a community. Case transfer policy in M1520.600 is applicable.

NOTE: Transfer procedures are applicable to individuals who are eligible in an Aged, Blind or Disabled (ABD) category. The Medicaid case of a child eligible in a Families and Children (F&C) category who is a patient in a DMHMRSAS facility is the responsibility of the local department of social services in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the local department of social services in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

B. Procedures

This section contains procedures to follow when an individual is admitted to a DMHMRSAS facility (M1550.401), when a patient leaves a DMHMRSASS facility (M1550.402) and when a patient is discharged from a DMHMRSAS facility to a nursing facility or Medicaid Community-based Care waiver services (M1550.403),

M1550.401 ADMISSION TO DMHMRSAS FACILITIES

A. Introduction

When a Medicaid recipient is admitted to a DMHMRSAS facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient.

B. Local Social Services

1. ABD Recipient

When an ABD recipient has been admitted to a DMHMRSAS facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

If the recipient is not in the DMHMRSAS facility for 30 days, the local EW must complete the DMAS-122 for the patient's stay in the facility, and must send it to the facility's Reimbursement office.

After the ABD recipient has been in the facility for 30 days, transfer the

Case to the appropriate Medicaid Technician in the appropriate DMHMRSAS facility. **Do not close the case.**

2. F&C Recipient

IF the patient being admitted is an individual eligible in a Families and Children (F&C) category, the case will NOT be transferred to the DMHMRSAS facility, but will be retained by the local department of social services. The individual will be considered temporarily absent from the home and will continue to be eligible in the F&C category as long as all non-financial and financial requirements are met.

C. DMHMRSAS Reimbursement Office

Send a DMAS-122 to the Medicaid Technician to advise of name of the patient, date of admission, facility, etc. The technician will take the following steps.

1. Inquire MEDPEND

The Technician will inquire through MEDPEND and MSI to see if the patient has a pending Medicaid application or is a current Medicaid recipient. If a pending case is found in MEDPEND and the Medicaid Technician has not received the case, the Medicaid Technician will contact the eligibility worker (EW) in the local department of social services which holds the patient's case and advise the EW that the recipient has been admitted to the facility. Pending applications must have eligibility determined with 15-90 days as per policy. The Medicaid technician will request that the case be transferred immediately.

2. Active Case Found

If inquiry into MSI indicates an active Medicaid case and the Medicaid Technician has not received the case, the Medicaid Technician will contact Medical Records at the end of 30 days to determine if the patient is still in the facility.

- If the patient is still in the facility, the Medicaid Technician will request that the case be transferred.
- If the patient has left the facility before the end of the 30 day period, the Medicaid Technician will advise the EW in the local agency that the individual has left the facility. Reimbursement will send the DMAS-122 to the local EW for completion.

3. No Active Case

If the patient has neither a pending application nor an active Medicaid case and Medicaid eligibility needs to be pursued, Reimbursement must submit a completed Application For Benefits on behalf of the patient, providing as much information as possible. Attach any verifications available and send to the Medicaid Technician.

D. Medicaid Technician

When a DMAS-122 is received from Reimbursement, search MEDPEND and MSI systems. NOTE: If the patient is between the ages of 21 and 65 and in an IMD, he or she cannot be Medicaid eligible while in the IMD> For other patients admitted, including those admitted as respite or emergency admissions, use the following procedures:

1. Pending Case in MEDPEND

If a pending case is found in MEDPEND, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notification of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.

2. Active Case in MSI

If an active case is found in MSI, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

a. If so, ask the EW in the local department of social services holding the case to transfer the case.

b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-122 to Reimbursement indicating that patient must be determined by the local agency because the patient was not in the facility for 30 days.

3. Transfer Case Received

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update CID and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.

4. Not Pending or Active Case

If neither a pending application nor an active Medicaid case is found, open a case using a completed Combined Application submitted by the Reimbursement Office on behalf of the patient.

a. If a case number is found in MEDPEND or MSI, use that case number to establish the hospital case.

b. If no case number is found in MEDPEND or MSI, but there is an inactive case in the facility, use the facility case number.

c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.

5. Respite or Emergency Admission

If the patient was admitted as a respite or emergency admission, notify the DMAS Policy Division of the patient's name and Medicaid recipient number.

6. Patient Discharged

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

M1550.402 PATIENTS DISCHARGED FROM DMHMRSAS FACILITIES

A. Introduction

When a Medicaid Patient in a DMHMRSAS facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an adult care residence (ACR), see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. DMHMRSAS Discharge Planner/ Social Worker/ Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an ACR or nursing facility will be transferred to the local department of social services in which he or she will be living.

C. Reimbursement Office

Send DMAS-122 to Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

Medicaid cases of patients discharged to a living arrangement which is not an ACR or nursing facility will be transferred to the local department of social services in which he or she will be living.

Do a desk review of all cases to be transferred to a local department of social services, **but do NOT determine if case will be eligible in the locality.** Update CID. Enter new city/county code, new address, and change worker number to M000.

Forward case containing all original Medicaid information, any verification provided by discharge planner/Reimbursement office, and DMAD-122, via certified mail to the appropriate local department of social services.

E. Eligibility Worker in Local DSS

When the case is received in transfer, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances. Send Case Record Transfer Form to the Medicaid Technician to notify of disposition of transfer.

M1550.403 PATIENTS DISCHARGED TO ACR

A. Introduction

When a patient in a DMHMRSAS facility will be discharged to an adult care residence (ACR), follow the procedures in this section.

B. DMHMRSAS Discharge Planner/Social Worker/ Reimbursement

The Medicaid case of a patient who will be discharged to enter an Adult Care Residence (ACR) will be transferred to the department of social services in the Virginia locality in which he or she last resided outside of an institution.

1. Medicaid Patient Discharge to ACR

For patients being discharged to an Adult Care Residence (ACR) who are Medicaid eligible in the DMHMRSAS facility, complete an Application For Benefits to apply for Auxiliary Grants (AG) and a Uniform Assessment Instrument. Attach copies of any verifications, a copy of the Community Placement Plan, the DMAS-122 and the DMAS-96. Send to the local department of social services immediately.

The Discharge Planner should not request information from the Medicaid case, but should complete the Application For Benefits providing the latest information available on the patient. The Medicaid Technician should also be given a copy of the Community Placement Plan and the DMAS-122 for the Medicaid case.

The Medicaid Technician will transfer the Medicaid case to the local department of social services. However, the AG application form should be sent immediately to the appropriate local department of social services in order to expedite processing, with a note that the patient's Medicaid case is being transferred to them. **The application must be received by the local department of social services in the month of the patient's entry to the Adult Care Residence in order for an AG payment to be made for that month, if eligible; no retroactive payments are made for AG.**

2. Patient Not On Medicaid, Discharged to ACR

For patients being discharged to an Adult Care Residence who are not Medicaid eligible in the DMHMRSAS facility, but for whom a AG/Medicaid application needs to be pursued, complete an Application For Benefits providing the latest known information on the patient, and a Uniform Assessment Instrument. Attach copies of any verifications available, a copy of the Community Placement Plane, the DMAS-122 and the DMAS-96.

Applications for patients being discharged to an ACR must be sent to the local department of social service sin the locality in which the patient last resided prior to entering the DMHMRSAS facility. If admission to the DMHMRSAS facility was from the out of state but the patient intends to remain in Virginia, the application must be sent to the Virginia locality in which the ACR is located. **Do not send any information to the Medicaid Technician located in the DMHMRSAS facility.**

The application must be received by the local department of social services in the month of the patient's entry to the Adult Care Residence in order for payment to be made for that month, if eligible; there are no retroactive payments made for AG.

C. Reimbursement Office

Send DMAS-122 to Medicaid Technician and DMAS to advise of the date the Medicaid patient will leave facility.

D. Medicaid Technician

Do a desk review of all cases to be transferred to a local department of social services, **but do NOT determine if case will be eligible in the locality.** Update CID. Enter new city/county code, new address, and change worker number to M000.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-122, via certified mail to the appropriate local department of social services.

E. Eligibility Worker in Local DSS

When the case is received in transfer, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send Case Record Transfer Form to Medicaid Technician to notify of disposition of transfer.

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a DMHMRSAS facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

B. DMHMRSAS Discharge Planner/ Social Worker/ Reimbursement

1. Patient Not On Medicaid

If the patient was not Medicaid-eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient of the patient's authorized representative may complete an Application For Benefits and send it to the appropriate local department of social services.

Applicants for patients being discharged to a nursing facility must be sent to the local department of social services in the locality in which the patient last resided prior to entering the DMHMRSAS facility. If admission to the DMHMRSAS facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

	2. Medicaid Patient	If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-122 and any other information necessary to transfer the Medicaid case record.
C.	**Reimbursement Office**	Send DMAS-122 to Medicaid Technician and DMAS to advise them of the date the patient will leave the facility.
D.	**Medicaid Technician**	Enter new case information on CID: city/county code, address and change worker number to M000. Send originals of case materials, copy of screening, Community Placement Plan and DMAS-122 to appropriate local DSS.
E.	**Eligibility Worker in Local DSS**	Do a full redetermination to determine if the recipient continues eligible for Medicaid in his or her new circumstances. Send "Case Transfer Form" to Medicaid Technician to advise of case disposition.